Boston Asthma Home Visit Collaborative
Referral Form

Family Agrees to referral: Yes __ No __ (if no, do not continue)

Patient Demographic Information

Patient Name:
D.O.B.:
Two years of age or older: **Yes ___** **No ____**
If under 2, rationale for referral: _____

Parent/caregiver name: **Language:**
Address:
Home Telephone: **Cell:**
Insurance: **ID#:**

Criteria for Referral (check all that apply)

___Poorly-controlled persistent asthma
___Hospital admission for asthma exacerbation in the last 12 months
___Repeated ER or urgent care visits for asthma in last 6 months
___Overuse of rescue medications in last 6 months
___More than one course of oral steroids in last 6 months
___Concerns about home environmental triggers:

___Patient smoke s **___Environmental Tobacco Exposure**
___Roaches **____ Mice** **___Animal Dander**
___Chemicals (cleaning chemicals, pesticides) **__ Molds**
___ Dust Mites **___Other:**

Additional Reasons for Referral (check all that apply)

___ Concerns about medication adherence
___Needs help with medication administration technique

Other pertinent information

Allergy testing conducted*: Yes _ __ No ___
Positive allergy testing results (pull-down menu):
___Roaches **___ Mice** **___Molds**
___Animal Dander **____ Dust-mite**

*We strongly encourage allergy testing, as recommended in the National Asthma Management Guidelines. Research shows that allergy test results help providers tailor interventions for improved health outcomes.

Referral Information

Date of referral: **Referrer name:**

Referrer is: ___ Primary Care Physician __ _ Asthma/Allergy Specialist
___ School Nurse ___ Insurer ___ Asthma Nurse/Educator __Other (please explain)

Referrer Phone # **Fax #** **Email:**

Primary Care Information

Primary Care **Physician Name**: **Email:**
Primary Care **Site**:
Primary Care Site **Phone:** **Fax#:**
Prim. Care Pedi Triage/Asthma Care Coord:
Name: **Email:**

Others requesting a report back (if not PCP or referrer)**:**

___ **Specialist**:
Fax #: Email:
___ **Insurer:**
Fax #: Email:
___ **Other:**
Fax #: Email:

Asthma Action Plan

(either FAX or attach the AAP, or fill out information below)

ASTHMA ACTION PLAN **GREEN ZONE**/Peak Flow Value _____
Controller medications:
Allergy medications:
ASTHMA ACTION PLAN **YELLOW ZONE**/Peak Flow Value _____
Rescue medications:
ASTHMA ACTION PLAN **RED ZONE**/Peak Flow Value _____

Equipment used (check all that apply)

___Nebulizer **___Spacer with mask**
___Spacer **___ Peak Flow**

FAX THIS FORM TO:

Nathalie Bazil, Boston Public Health Commission: 617 534-2372 (fax); nbazil@bphc.org
WITH ASTHMA ACTION PLAN!